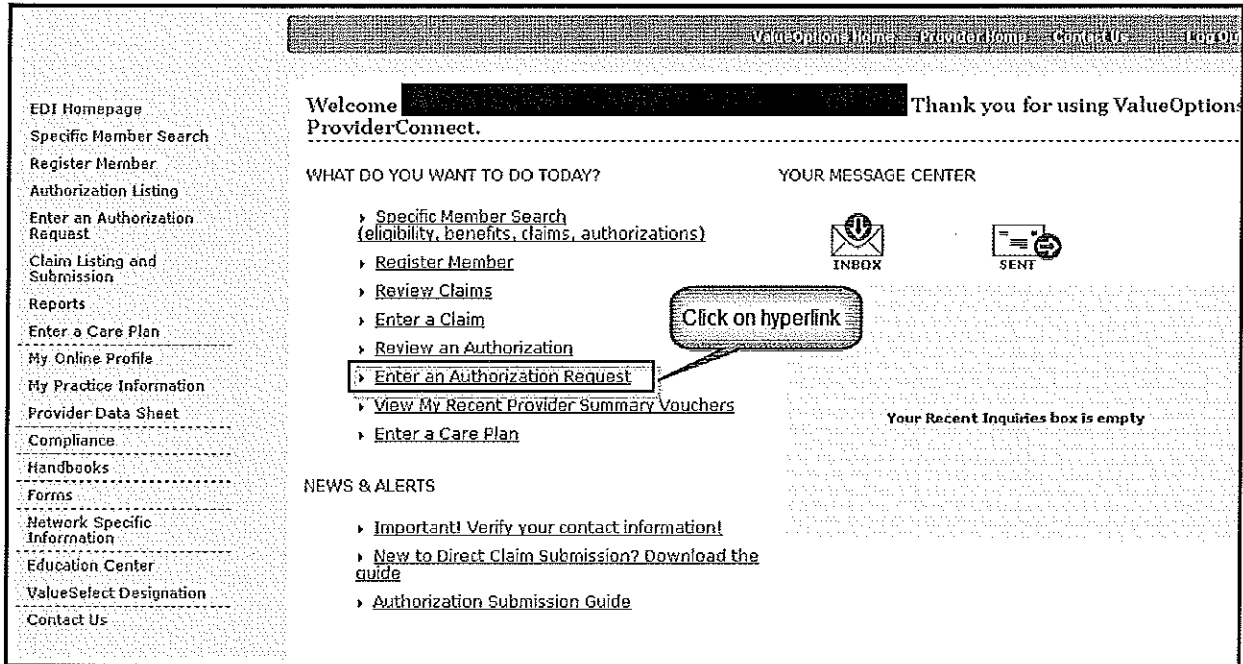


Maryland Public Mental Health System (PMHS)

Tips for Submitting Authorization Requests through ProviderConnect

Providers after logging in will initially be viewing their home page. Authorization Requests are started by utilizing the *Enter an Authorization Request*:



After selecting *Enter an Authorization Request* providers will be directed to a disclaimer page and then to a *Search a Member* page where Member ID and Date of Birth are required elements. System defaults to current date for As of Date but can be changed as needed. Consumer ID can be MAPS ID, Uninsured ID, or ValueOptions Consumer ID.

Provider Connect Home

Search a Member

Required fields are denoted by an asterisk (*) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

*Member ID (No spaces or dashes)

Last Name

First Name

*Date of Birth (MMDDYYYY)

As of Date (MMDDYYYY)

Providers will be offered a page to confirm the consumer information and then must select the correct servicing address on the **Select a Service Address** page. This address needs to be a match to the primary address that provider is servicing consumer at and is key to successful navigation through the request process. Funding streams, program codes and provider types concerning OMS provider status are linked to this address selection.

Provider Connect Home

Provider

Provider ID Provider Last Name Provider First Name

Select Service Address

If provider has more than 1 active servicing address - these will all display

Provider	Vendor														
<table border="1"> <tr> <td>Provider ID</td> <td>Last Name</td> </tr> <tr> <td>First Name</td> <td></td> </tr> <tr> <td>Tax ID</td> <td>Service Address</td> </tr> <tr> <td>Alternate ID</td> <td></td> </tr> </table>	Provider ID	Last Name	First Name		Tax ID	Service Address	Alternate ID		<table border="1"> <tr> <td>Vendor ID</td> <td>Vendor Last Name</td> </tr> <tr> <td>Vendor First Name</td> <td></td> </tr> <tr> <td>Paid To Vendor ID</td> <td>Pay To Address</td> </tr> </table>	Vendor ID	Vendor Last Name	Vendor First Name		Paid To Vendor ID	Pay To Address
Provider ID	Last Name														
First Name															
Tax ID	Service Address														
Alternate ID															
Vendor ID	Vendor Last Name														
Vendor First Name															
Paid To Vendor ID	Pay To Address														

The next page is the **Requested Services Header** page. Selection on this page is key to ensuring the correct forms display and the correct authorization request is placed in the system. See appendix at end for easy reference on how to choose correctly. The **Requested Services Header** page will refresh and redisplay depending on options selected. Examples of Inpatient and Higher Levels of Care as well as Outpatient Services are displayed below:

Home

Requested Services Header

All fields marked with an asterisk () are required.
Note: Disable pop-up blocker functionality to view all appropriate fields.*

*Requested Start Date/OMS Interview Date (MM/DD/YYYY)

09082009

OK

*Level of Service

INPATIENT/HLOC

▼

*Type of Service

MENTAL HEALTH

▼

*Level of Care

INPATIENT

▼

Type of Care

INPATIENT MENTAL HEALTH- ACUTE

▼

*Admit Date (MM/DD/YYYY)

09082009

OK

Provider

Tax ID

Provider ID

Provider Last Name

Vendor ID

Provider Alternate ID

Consumer

Consumer ID

Last Name

First Name

Date of Birth (MM/DD/YYYY)

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type:

Does this Document contain clinical information about the Consumer?

Yes ☐ No ☐

*Document Description

SELECT...

▼

Upload File

Click to attach a document

Delete

Click to delete an attached document

Attached Document:

Back

Next

Once all info is entered click **Next** - you will be prompted on whether or not you wish to attach a document - this is last chance to attach documents to the request - but they are not required. Continue with options to move forward.

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Home

Requested Services Header

All fields marked with an asterisk () are required.
Note: Disable pop-up blocker functionality to view all appropriate fields.*

*Requested Start Date/OMS Interview Date (MM/DD/YYYY)

09082009

OK

*Level of Service

INPATIENT/HLOC

▼

*Type of Service

MENTAL HEALTH

▼

*Level of Care

INPATIENT

▼

Type of Care

INPATIENT MENTAL HEALTH- ACUTE

▼

*Admit Date (MM/DD/YYYY)

09082009

OK

Provider

Tax ID

Provider ID

Provider Last Name

Vendor ID

Provider Alternate ID

Consumer

Consumer ID

Last Name

First Name

Date of Birth (MM/DD/YYYY)

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type:

Does this Document contain clinical information about the Consumer?

Yes ☐ No ☐

*Document Description

SELECT...

▼

Upload File

Click to attach a document

Delete

Click to delete an attached document

Attached Document:

Back

Next

Once all info is entered click **Next** - you will be prompted on whether or not you wish to attach a document - this is last chance to attach documents to the request - but they are not required. Continue with options to move forward.

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3 | Page

[Provider Connect Home](#)

Requested Services Header

All fields marked with an asterisk () are required.
Note: Disable pop-up blocker functionality to view all appropriate links.*

*Requested Start Date/KMS Interview Date (MM/DD/YYYY)

*Level of Service

*Type of Service *Level of Care *Type of Care

Provider

Tax ID	Provider ID	Provider Last Name	Vendor ID	Provider Alternate ID

Consumer

Consumer ID	Last Name	First Name	Date of Birth (MM/DD/YYYY)

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type: Does this Document contain clinical information about the Consumer? ☒ Yes ☐ No

*Document Description:

Attached Document:

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Complete the clinical information as applicable to the type of care and services being requested. These screens vary between Inpatient/HLOC and Outpatient/Community Based services.

Hints for successful submission/navigating screens include:

- Required fields have "*" next to them – these fields are required every time
- Some fields are dependent on other fields – a positive or negative response to a previous question may result in other fields being required – Example is question ***"Is this Consumer a Veteran?"***– Yes then requires selection of the most recent war consumer is a veteran of.
- Use of hyperlinks to search with pop ups – partial information in field may assist in narrowing search for desired information. If information is known and field is free text the information can be typed straight in – example is ***Axis 1 Diagnosis Code***.

PAGE 4 of 11

Requested Services Header

Requested Start Date: 09/08/2009
Level of Service: INPATIENT/HLOC
Type of Request: INITIAL

Note: Disable pop-up blocker functionality to

Diagnosis

Please indicate primary diagnosis.

Axis I

* Diagnosis Code 1: 296.01
Description: BIPOLAR I DISORDER, SINGLE MANIC EPISODE, MILD

Diagnosis Code 2:
Description:
Diagnosis Code 3:
Description:
Axis III

Select Diagnosis Code 2 - Microsoft Internet Explorer

Code	Description
296.01	AFFECTIVE PSYCHOSES
296.02	MANIC DISORDER SINGLE EPISODE
296.03	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, UNSPEC
296.04	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, MILD
296.05	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, MODERATE
296.06	BIPOLAR I D/O, SINGL MANIC EPIS, SEV W/O PSYCH FTRS
296.07	BIPOLAR I D/O, SINGL MANIC EPIS, SEV W PSYCH FTRS
296.08	BIPOLAR I D/O, SINGL MANIC EPIS, IN PRTL REMISSION
296.09	BIPOLAR I D/O SINGL MANIC EPIS, IN FULL REMISSION
296.10	MANIC DISORDER RECURRENT EPISODE
296.11	MANIC DX- RECURRENT- UNSPECIFIED DEGREE
296.12	MANIC DISORDER RECURRENT EPISODE MILD DEGREE
296.13	MANIC DISORDER RECURRENT EPISODE MODERATE DEGREE
296.14	MANIC DX-RECURRENT-SEVERE W/O PSYCHOSIS
296.15	MANIC DX-RECURRENT-SEVERE W/PSYCHOSIS
296.16	MANIC DX-RECURRENT-PARTIAL/UNSPECIFIED REMISSION
296.17	MANIC DISORDER-RECURRENT EPISODE-FULL REMISSION
296.2	MAJOR DEPRESSIVE DISORDER SINGLE EPISODE

- Drop-downs are available throughout the flow to standardize responses where possible
- Help Text is available as hover text or pop up on various screens – moving cursor over the field or double clicking may help with additional information
- For fields where response is something other than the options offered – frequently there is an “Other” option that will then provide a free text box to utilize in completing information – *Psychotropic Medications* is one such field

1. Medication

Medication: OTHER
Description: OTHER

Other: Text Field for Other

Dosage: Frequency: SELECT...

Is medication found to be effective? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Side effects? ☐ Yes ☐ No
Usually adherent? ☐ Yes ☐ No
Prescriber: SELECT...

2. Medication

Medication:
Description:

Dosage: Frequency: SELECT...

Is medication found to be effective? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Side effects? ☐ Yes ☐ No
Usually adherent? ☐ Yes ☐ No
Prescriber: SELECT...

Other Text Box only appears if Other is selected - allows free text entry of meds not available in the pop up

- Some fields will auto fill from 1 review to the next – information may or may not be modifiable depending on the nature of the information
- **Red Dot Error Messages** are there to help providers complete all the information and to offer help

• The information you provided for Axis I Diagnosis Code 1 appears to be incorrect. Please check your information and re-enter (click on 'diagnosis' to activate search). If you believe that you have entered this information correctly, please contact ValueOptions' Customer Service.

Note: Disable pop-up blocker functionality to view all appropriate links.

Diagnosis

Please indicate primary diagnosis.

Axis I

Axis II

* Diagnosis Code 1	Description	* Diagnosis Code 1	Description
29623		799.9	DIAGNOSIS DEFERRED (AXIS 1 OR 2)

Decimal point is missing on Diagnosis Code 1 - must be corrected to complete request

After all data is completed the final pages are dependant again on whether this is Inpatient/HLOC or Outpatient/Community Based.

- All Inpatient/HLOC will pend for further review
- Outpatient/Community Based requests will either **Approve**

Determination Status:

APPROVED

Provider ID

Subscriber Name

Subscriber ID

Provider Alternate ID

Consumer Name

Consumer ID

Consumer DOB

Provider Name & Address

Authorization #

Client Authorization #

SALISBURY MD 21801

090809-1-14

N/A

Date of Admission/Start of Services

From To

Type of Request

09/08/2009

09/08/2009 - 03/08/2010

INITIAL

Level of Treatment

Type of Treatment

OUTPATIENT/COMMUNITY BASED

MENTAL HEALTH

Reason Code

A70

Important key elements on authorization available on page

Place of Service	CPT	Modifier	Service Units	Description	Units/Visits
52		113		OUTPATIENT/COMMUNITY BASED	5
Total Units For Auth 090809-1-14 From 09/08/2009 To 03/08/2010				5	
Total Units Authorized This Episode For 090809-1-14				5	

Message

A70

Claims payment is restricted to services for which the provider is contracted to deliver and is conditional upon services authorized, clinical necessity, and the enrolled consumer being eligible for services on the date of service. Clinical authorization is not a guarantee of payment.

If further authorization is required for treatment of this consumer, please submit a new request prior to the end date of the current authorization or exhaustion of the number of units.

Options to print just the **Results** page, the entire **Authorization Request** as well as **Return to Provider Home** page

Attached Documents

Document Title Document Description

There are no documents attached with this Authorization Request

Authorization Printing Options

(For the best print results, please print in 'Landscape' format)

Print Authorization Request

Click to print the entire Authorization requested

Print Result

Click to print the Results page

Return to Provider Home

Click to return to the ProviderConnect homepage

- Or Pend for Further Review

Determination Status:

***** PENDING *****

Provider ID

Provider Alternate ID

Provider Name & Address

SALISBURY MD 21801

Please Note: This is NOT an Authorization for Care. The services requested require additional review. You will be contacted regarding the status of this request.

Subscriber Name Subscriber ID

Consumer Name Consumer ID Consumer DOB

Pending Authorization # Client Authorization #

090809-1-15 N/A

Date of Admission/Start of Services Requested From Type of Request
09/08/2009 09/08/2009 INITIAL

Level of Treatment Type of Treatment Level of Care
INPATIENT/HLOC MENTAL HEALTH INPATIENT

Reason Code

P77

Message

P77

Attached Documents

Document Title Document Description

There are no documents attached with this Authorization Request

Authorization Printing Options

(For the best print results, please print in 'Landscape' format)

Print Authorization Request

Click to print the entire
Authorization requested

Print Results

Click to print the
Results page

Return to Provider Home

Click to return to the
Provider Connect homepage

Same key information and
options on printing on a
Pending request

- Or offer option on a set number of units if approved – Accepting this will allow provider to proceed with request and give details on the specific services being requested

[ProviderConnect Home](#)

Requested Services Header

Requested Start Date 09/08/2009	Level of Service OUTPATIENT/COMMUNITY BASED	Consumer Name	Provider Name	Vendor ID
Type of Request INITIAL	Consumer ID	Provider ID	Provider Alternate ID	

If your request is approved, you will receive 5 visits.
 If you agree to accept this number of visits, please select "Accept". If you do not agree, please select "Reject" and you may enter your modified request.
 Please be aware that if your request is above the offered number of units, it may be pended for additional clinical review.

Accept these services allows the authorization process to continue and may result in auto approval or provide the reviewing staff to better understand the request

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The provider on the Outpatient/Community Based requests that are offered the **Accept/Reject** option will then be asked to indicate the specific **Place of Service, CPT Codes** and **Modifiers** as well as adjust the units to those specific codes as they require. This entry of information allows the care managers and CSAs to understand the request and complete the review process. The number of units and services will be reviewed and adjusted to match the authorization process specific to that type of care. These requests may approve or pend depending on the type of services being requested.

ProviderConnect - Request Services - Request Services - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Search Favorites

Address http://pcrl1dev/pc/review/RequestORF2AcceptReject.do

bing News Entertainment Video Sports Money Autos

ABUSE PLAN PLAN SERVICES

PAGE 7 of 8

Requested Services Header

Requested Start Date: 09/08/2009
 Level of Service: OUTPATIENT/COMMUNITY BASED
 Consumer Name: [REDACTED]
 Provider Name: [REDACTED]
 Vendor ID: [REDACTED]
 Type of Request: INITIAL
 Counselor: [REDACTED]

All fields marked with an asterisk () are required.
 Note: Disable pop-up blocker functionality to view all appropriate links.*

Select **Place of Service** that matches where services are provided. **CPT Code** and **Modifiers** are key to correct services - particularly for Supported Employment and PRP Services. Units can be spread between more than 1 **Place of Service**, **CPT Code** and **Modifier** if appropriate. Care Managers and CSAs will review and adjust if necessary.

Requested Services

Place of Service	*CPT or HCPC Code	Modifier (if Applicable)	*Units/ Units
MOBILE UNIT (OFFSITE)	n2018	u3	5
MOBILE UNIT (OFFSITE)			
NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY			
NURSING FACILITY			
OFFICE			
OUTPATIENT CHEMICAL DEPENDENCY PROGRAM			
OUTPATIENT HOSPITAL			
PHARMACY			
PRISON/CORRECTIONAL FACILITY			
PRISON/CORRECTIONAL FACILITY			
PSYCHIATRIC HOSPITALIZATION (CONSULT)			
PSYCHIATRIC RESIDENTIAL TREATMENT CENTER			
SELECT...			
SELECT...			
SELECT...			
SELECT...			

Done Local intranet

Appendix for requesting various Types of Care

Services Requesting	Level of Service	Type of Service	Level of Care	Type of Care	Notes
Inpatient – Acute	Inpatient/HLOC	Mental Health	Inpatient	Inpatient Mental Health Acute	All Inpatient/HLOC Requests will pend
Hospital Diversion	Inpatient/HLOC	Mental Health	Inpatient	Hospital Diversion	
Partial	Inpatient/HLOC	Mental Health	Partial Hospital	Partial Hospitalization	
IOP	Inpatient/HLOC	Mental Health	Intensive Outpatient	Intensive Outpatient Program	
RTC	Inpatient/HLOC	Mental Health	Residential	RTC - Routine	
Crisis Residential	Inpatient/HLOC	Mental Health	Crisis Residential	Residential Crisis	
OMS Outpatient	Outpatient/Community Based	Mental Health	Outpatient	OPMH OMS	May auth or pend
Non OMS Outpatient	Outpatient/Community Based	Mental Health	Outpatient	OPMH NON OMS	May auth or pend
Supported Employment	Outpatient/Community Based	Mental Health	Supported Employment	Supported Employment	May offer units to cover Supported Employment. Will be asked to complete CPT codes and Modifier selection - All will pend for review
TBI Services	Outpatient/Community Based	Mental Health	TBI Waiver	TBI Waiver Services	All will pend for review
PRP	Outpatient/Community Based	Mental Health	Outpatient	Psychiatric Rehabilitation	May offer units to cover PRP services. Will be asked to complete

					CPT codes and Modifier selection - All will pend for review – utilize if PRP services for PRP, PRP1 or PRP2
RRP Beds	Outpatient/ Community Based	Mental Health	Outpatient	Residential Rehab	May offer units to cover RRP bed and PRP services. Will be asked to complete CPT codes and Modifier selection - All will pend for review – utilize for PRP and RRP bed for PRP3 and PRP4 – auth will be adjusted by the CSA to 1 year as appropriate
Occupational Therapy	Outpatient/ Community Based	Mental Health	Outpatient	Occupational Therapy	All will pend for review
TBS Services	Outpatient/ Community Based	Mental Health	Outpatient	Therapeutic Behavioral Services	All will pend for review
Supported Housing	Outpatient/ Community Based	Mental Health	Supported Housing	Supported Housing	All will pend for review
Mobile Treatment	Outpatient/ Community Based	Mental Health	Mobile Treatment/ACT	Mobile Treatment/ACT	All will pend for review
Respite	Outpatient/ Community Based	Mental Health	Respite	Respite Services	All will pend for review
Case Management	Outpatient/ Community Based	Mental Health	Outpatient	Case Management	All will pend for review